CFC 804A

Choices for Care

Nursing Facility (or Hospital Swing Bed) Discharge Notice Form

Complete this form for discharges of individuals who are on the Choices for Care program only. This notice does not in any way replace or change any of the nursing home regulatory requirements for discharge or transfers.

Individual Name: _____
SSN: _____ Date of Birth:_____
Legal Representative (if any):_____
Nursing Facility: _____ Phone:_____

A. TYPE OF DISCHARGE: Discharge Date: _____

☐ *Discharge WITHOUT Choices for Care Services – ***complete signature below and section B***
☐ Discharge WITH Choices for Care in a different setting – ***complete section B & C***
☐ Death (*skip remaining sections*)

***I am voluntarily withdrawing from Choices for Care, long-term care Medicaid services. I understand I may still access other services that I am eligible for. I understand that I may reapply for the Choices for Care program at any time.**

_____ _____
Individual/Legal Representative Signature *Date*

B. DISCHARGED TO:

☐ Own Home
☐ Home of Another: (name)_____
☐ Hospital Swing Bed: (name)_____
☐ Nursing Facility: (name)_____
☐ Residential Care Home: (name)_____

Address discharged to:_____
_____ Phone Number:_____

C. CHOICES FOR CARE Case Management Agency:
The individual or legal representative must choose a Choices for Care case management agency/consultant. ***The nursing facility or hospital swing bed provider must make a referral to the chosen case management/consultant agency prior to discharge.***

☐ Area Agency on Aging_____*(agency name)*
-OR-
☐ Home Health Agency_____*(agency name)*

☐ Consultant Agency (cash & counseling option ONLY)_____*(agency name)*

Person Completing Form (print): _____
Signature: _____ Date: _____

Distribution: Copy to local DAIL LTCCC and DCF

01/16/05